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AUTHOR Parker, Kandis Cooke
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ABSTRACT

This paper explores the literature on attachment disorders in order to discover if the school setting can be an appropriate treatment option for children with mild attachment disorders, and in order to investigate how counselors can implement this treatment option. The introduction discusses the effects of recent changes in family structure on children. Chapter 2 explores the history of attachment theory, citing several studies that provided the basis for the discipline. In Chapter 3, the theoretical underpinnings of attachment theory are delineated and traced to their origins in psychoanalysis, developmental psychology, and ethology. Chapter 4 defines and illustrates the current attachment model, whose basic elements are trust of caregiving, trust of control, and trust of self. Attachment disrupters are analyzed, including prebirth and birth factors, learning disabilities, physical handicaps, parenting factors, trauma, foster care, adoption, and day care. Symptoms of attachment disorders and treatment options are also discussed. Chapter 5 proposes a model for school-based treatment of children with mild attachment disorders, and reports the results of an informal survey with Wyoming school counselors (N=26) that indicated a need for greater knowledge in their schools about attachment disorders. The paper concludes with recommendations for legislation, on-site child care programs, and evaluation of day-care centers by users. (TE)

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Attachment Disorders: A Proposed Model for the School Setting

by

Kandis Cooke Parker

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INTRODUCTION

That there is a bonding process between mother and child is not a new idea, however bonding has recently come to the forefront as a reason for many difficulties children and young adults experience today. Society is going through a time of great transition, a demographic revolution that is altering the American family as well as the American workforce (Schroeder, 1987, p. 14). This alteration has brought both positive and negative changes. How individuals chose to respond to these changes will determine their future but more importantly, the future of their children. Today, with mothers spending less time at home; with families falling apart and being reshaped into new combinations; with debates raging about the emotional needs of school children; and with the arguments about the advantages and disadvantages of day care, understanding bonding seems more urgent than ever before (Karen, 1990). These unbonded children, who become the victimizers of adults, parents, and other children are growing in great numbers and will continue to grow if the problem of bonding is not addressed.

The existence of these children is indicated by overflowing residential treatment centers where it can take up to three years for a child to be admitted to the program due to the large waiting lists (R. Curtis, personal communication, December 3, 1990). Also in evidence are those schools where behavioral difficulties are consuming an inappropriate amount of time and energy and teachers as well as administrators are admitting there are severely problematic children whose needs cannot be met in the school setting. More evidence is visible through the adoption agencies and foster care programs where there is a growing phenomenon of returning unwanted children (Sachs, 1990).

If society chooses to deny the importance of attachment there may be future generations that have huge numbers of unbonded children. If the proper bonding and subsequent attachment does not occur-usually between mother and child-the child will develop mistrust and deep-seated rage. The child will become a "child without a conscience" (Magid & McKelvey, 1987, p. 3).

Statement of Purpose

The purpose of this paper is to explore the literature on attachment disorders, which will include historical aspects, theoretical underpinnings, attachment cycle disrupters, and causes of attachment disorders. Treatment methods will be considered as well as a proposed model for identifying and working with these high risk children. Implications for counselors and teachers will also be addressed. An informal survey was taken for the purpose of gaining insight into what is known about attachment disorders and how they are being addressed in the Wyoming public school systems. The results of this survey will be discussed in chapter 5.

Definition of Terms

The bonding process: occurs at the beginning of life when the scales are tipped toward a future of trust and love or one of mistrust and deep-seated rage (Magid & McKelvey, 1987).

A bond: is the link between two individuals that endures through space and time and serves to join them emotionally.

Attachment: is the process through which the child develops trust in the primary caregiver and develops the ability to establish and maintain significant interpersonal relationships (Ainsworth, 1973). Psychoanalysts have agreed

that a child's first human relationship is the foundation stone of his or her personality (Bowlby, 1969). Thus, if in the first relationship, trust or successful attachment is achieved then the child will most likely have the ability to give and receive trust in other relationships. However, if the child does not achieve trust and the attachment is unsuccessful the likelihood of this child being able to either establish or maintain relationships is minimal at best.

Non-attachment: refers to the incapacity of the person to form human bonds. In personal encounters with such individuals there is an almost perceptible feeling of intervening space, a remoteness of 'no connection' (Fraiberg, 1977, p 47). These people do not have the sense of their own existence, there is a deadness within and to feel alive they must resort to mostly inappropriate extrinsic behaviors since there is nothing within their own core.

Attachment Disorder: Is when the attachment process goes awry or is not completed. A child with an attachment disorder lacks the ability to give and receive trust and affection. They are also cruel to others, exhibit phoniness, often steal and hoard, have problems with speech and eye contact, can be preoccupied with gore, blood, and fire, demonstrate a superficial attractiveness and friendliness with strangers, and can display various types

of learning disabilities. Their concern is always 'what is in it for me?', with no thought of anyone else.

Caution must be observed so as not to make the mistake of blaming all human ills on failure in early nurturing. Other conditions are known which can affect the capacity to love and the regulation of drives. Yet, the implications of primary caregiver deprivation are far-reaching and seem to be encompassing many more of societal ills than previously believed.

Limitations of the Study

The first three sections in Chapter 4 are excerpts from an inservice program presented by Ray Curtis, MSW, Forest Heights Lodge Residential Treatment Center. The attachment model referred to in this section is the one used at Forest Heights Lodge, The Attachment Center at Evergreen, Albany County Schools as well as several schools and clinics nationwide (R. Curtis, personal communication, Dec. 3, 1990). This model can also be found in Magid and McKelvey (1987). The attachment cycle disrupters listed are representative of Forest Heights Lodge's beliefs of the reasons children become unattached.

In Chapter 4, the continuum that is presented was developed from the information furnished by Curtis, Fay, Meyers and Chapman through personal communications.

The proposed model presented in Chapter 5 is limited to

children with mild attachment disorders who are in the regular classroom. Whereas the behavioral disorder class utilizes therapies and techniques that are specific to the severe student in the self contained classroom this model specifically addresses the mildly disordered student.

CHAPTER II

HISTORICAL OVERVIEW OF ATTACHMENT DISORDERS

John Bowlby'S Work with The World Health Organization

During the 1930s and the 1940s a number of clinicians were beginning to make observations about the poor effects on personality development of children who had been placed in institutional care and/or had frequent changes of their mother-figure during the early years of their life (Bowlby, 1988). These clinicians included Winnicott (1987), Bowlby (1982), Burlingham and Freud (1944), Spitz (1965). Of those individuals, it was John Bowlby who was asked to be a consultant for the World Health Organization in 1950 (Bowlby, 1951). His work with that organization included researching and reporting on the mental health of homeless children, who were of great concern in post war years. Bowlby published his report, Maternal Care and Mental Health, in 1951. In that report he warned against separating children from their mothers - even mothers who were untidy and neglectful (Bowlby, 1951). His assertion was that maternal deprivation could lead to physical and mental illnesses and a child would be at risk, even in a

good institution, if true maternal care was unavailable. In another conclusion of the report Bowlby revealed that

> deprived children, whether in their own homes or out of them, are a source of social infection as real and as serious as diphtheria or typhoid: and just as preventive measures have reduced these diseases to negligible proportions, so can determined action greatly reduce the number of deprived children in our midst and the growth of adults liable to produce more of them (Bowlby, 1951, p. 157).

Studying those conclusions, Bowlby could see that bonding with a mother-figure was imperative for the healthy development of a child to occur.

To obtain these conclusions, Bowlby had drawn from information and experiences of his earlier research. In the 1930s, while working in a child treatment center, Bowlby was supervised by Klein, the inventor of psychoanalytic play therapy and one of the first object-relations theorists. Bowlby broke with the Klienans when he discovered that their focus was entirely 'internal relationships' and that they did not believe the notion that internal relationships reflect external relationships as Bowlby did. He held that real-life events, the way parents treat a child, are of key

importance in determining development (Karen, 1990).

Even though Bowlby had critics such as Klein, Freud, and Spitz, he continued his work emphasizing the importance of the mother-infant bond and the critical importance of the quality of mothering.

James Robertson's Hospital Study

As Bowlby's work continued he was influenced by the findings of Robertson, a social worker. Robertson had been observing young children who were being sent to the hospital, where in the 1950s parents were allowed only very few visits. He recorded the agony and despair these children experienced. Although his observations were very skillfully done, psychiatric experts refused to believe that agony and trauma really occurred. Robertson then decided to film an episode to prove his claims about these children. The end product was the documentary A Two Year Old Goes to the Hospital. This piece of work held a two-fold reward for Robertson. First, it led to a critical decision about research strategy, which was that of using infants and children in research. This decision, according to Bowlby (1969) was logical

> since our aim was to understand how these pathological processes originated and developed, we decided that henceforward we would take as our principle data detailed records of how young children

> respond to the experiences of being separated from and later of being reunited with mother (Bowlby, 1969, p. 14).

This data seemed to compliment the data traditionally gathered from adult subjects. The second reward of the film was that it was influential in changing hospital policies about parental visitation. Many hospitals would now allow parents unrestricted visits as well as the option of staying overnight with their child.

Robertson's work pioneered a number of additional studies about children being separated from their parents. Of those studies, McCarthy, Lindsay, and Morris (1962), Micic (1962), and Fagen (1966), the conclusions showed that a strange environment is not the principle cause of a child's distress and that the absence of mother greatly increases this distress (Bowlby, 1969). Bowlby and Robertson continued their investigations at Bowlby's Tavistock Clinic in London, where they were joined by Mary Ainsworth.

Mary Ainsworth's Research

Mary Ainsworth first became aware of the issues involved in relatedness while a student at the University of Toronto in 1929. Her first mentor was a psychology instructor, William Blatz, who intrigued Ainsworth with his

'security theory' (Blatz, 1966). Ainsworth was impressed by his ideas that a child derived security from being with the parents. Going further into detail, Ainsworth explained

> that security enables him to move out, to explore his world, to learn about it, and to acquire the skills to master what he encounters out there. I do not remember if he called that 'using the parent as a secure base from which to explore the world, but that is how I finally came to phrase it (Karen, 1990, p. 42).

Ainsworth eventually wrote her doctoral dissertation on Blatz's security theory (Salter, 1939). She lectured at the university and co-directed a study team with Blatz. In 1950 Ainsworth accompanied her husband to London where she answered a help-wanted ad for Tavistock Clinic. During the first interview, Bowlby could see that their interests coincided remarkably and hired her. Bowlby felt Ainsworth could be of great help in fighting the analytic establishment as he believed he had been doing single-handedly for many years. From 1950 - 1954 Ainsworth worked with Bowlby's staff reviewing data and giving recommendations on the future direction of their research (Gosling, 1973). She was very impressed with Robertson's work and vowed to use his methods of direct observations in

the natural environment as the basic structure of any of her own research.

The Uganda Study

Ainsworth and her husband traveled to Uganda in 1954 where she launched a study of her own. This study would prove to be one of the pioneering studies in modern infant attachment research (Ainsworth, 1967).

Ainsworth used twenty-eight Uganda babies from different villages. She observed these babies in their homes and immediately began to believe that Bowlby was right. Babies are not passive, recipient creatures who attach to the person that satisfies their needs (Karen, 1990). These babies exhibited specific attachment behaviors, one of which was 'differential stopping of crying' (Ainsworth, 1967). If the babies cried when someone else held them and stopped crying immediately when taken by the mother they were thought to be differentiating between the mother and someone else. Ainsworth observed many different situations where attachment to the mother could be spotted, even when the other person (the non-mother) was familiar to the baby. This study was the first major study outside Bowlby's clinic that offered empirical data to support Bowlby's theory of attachment (Bowlby, 1969). Ainsworth believed that the identification of patterns of attachment behavior was the most significant

yield of the Uganda Study (Ainsworth, 1967).

Her next longitudinal study was a replication of the Uganda Study with the exception that the study was located in Baltimore. The conclusions of the "Baltimore Studies" were the same as in the Uganda Study. She could identify attachment behavior patterns suggesting that babies everywhere speak the same attachment language (Ainsworth, Blehar, Waters, & Wall, 1978).

Harlow's Rhesus Monkey Study

Research by Harry Harlow proved to be a pioneering contribution to attachment research. Harlow, an animal learning theorist, began experimenting with rhesus monkeys in an attempt to disprove both Freudian and social learning theorists who believed that an infant attaches to the mother as a function of feeding (Harlow, 1971).

In the experiment, rhesus infants were taken from their mothers at birth and raised by two surrogate mothers. One mother was made of mesh wire and the other of mesh wire covered with terry cloth. Both were equipped with feeding nipples. When the nipple was removed from the terry cloth mother the infants continued to attach to that mother, using her as a base for explorations as well as cuddling and seeking safety when frightened. Even though Harlow's study seemed to be headed in the direction of conclusions about attachment, there were no definitive conclusions that could

be made about human infants.

Ainsworth's Strange Situation Study

Ainsworth, armed with Harlow's findings, the Uganda and Baltimore studies, set out to develop an instrument to assess human infant attachment. Thus, the Strange Situation Study was born (Ainsworth, et al. 1978).

The Strange Situation study investigated a set of episodes in both the home and laboratory settings. These episodes involved the mother, the infant, and a stranger. It was planned that each episode be more stressful than the previous one. The babies were observed first with their mothers in an unfamiliar, non-threatening setting to see how far from their mothers they would move to explore the toys in the room. Next, a stranger was introduced into the setting and gradually approached the babies. The third episode saw the mothers leaving the room and in the fourth episode the mothers returned and the stranger left. "The mothers were instructed to interest the babies in the toys again, in hope of restoring their exploratory behavior to the baseline level characteristic of when they were previously alone with their mother" (Ainsworth et al. 1978, p. 33). After that episode, a second separation occurred when the mothers left and the babies were left alone in the unfamiliar environment. To check on whether there was more distress to being alone or being separated the second time

and to ascertain whether the presence of a stranger was more distressing than separation, the stranger returned before the mother returned (Ainsworth, et al. 1978).

The Strange Situation findings began a critical shift in the thoughts about infancy and child-rearing. This procedure could assess the effects of non-drastic separation and loss as well as the effects of the everyday details of parenting (Bowlby, 1973). Since the teams of observers had observed the mother-infant pairs for seventy-two hours in their naturalistic environment, Ainsworth was able to make specific associations between the baby's attachment styles the mother's parenting styles. This was the first empirical instrument to assess relatedness and how styles of parenting contributed to individual differences and was Ainsworth's dream since her days at the University of Toronto. The Strange Situation categories have held up for over twenty years and studies of thousands of children.

Ainsworth spent the next twenty years working with the Strange Situation studies and training others to use the technique. This work led to the published form of her findings, Patterns of Attachment (Ainsworth et al. 1978).

Continuing the Research

As Bowlby and Ainsworth continued in their efforts through lectures, writings, and books new students interested in attachment theory began to emerge. Among them

was Inge Bretherton, who rejected the behavioralist climate of the times. She also believed that Ainsworth's work with real children in real environments and developmental psychology far out-weighed behavioral ideas of conditioning and rewarding (Bretherton & Waters, 1985).

Other students of Ainsworth were beginning to branch out with their own research and the attachment theory movement was well on its way. At the University of Minnesota, Everett Waters and Alan Sroufe encouraged the Minnesota Institute of Child Development to enter into the attachment research domain which really gave support to the movement.

The Strange Situation's value seemed to come more into focus for infancy researchers who believed they had been given an extraordinary tool, "a Rosetta stone of sorts" (Karen, 1990, p. 49) that they could use to trace an infant's interaction with his parents.

Present and Future

Attachment researchers such as Sroufe, Main, and Mahler (Bowlby, 1988) have stimulated new thinking about early bonding and this stimulation is leading to more research and more findings which support and nurture attachment theories. Bowlby and Ainsworth are still formidable and dominating individuals in the field of attachment. They have experienced their own research successes and failures,

collaborated through the years, taught, trained, and lectured to many and now are seeing the fruits of their labors being actualized as the field of attachment research has grown into a legitimate discipline of its own, just as someone watches a child grow from infancy to adulthood.

CHAPTER III

THE THEORY OF ATTACHMENT

Attachment theory was born out of the sciences of ethology, developmental psychology and psychoanalysis. Bowlby, said to be the father of attachment theory, combined his knowledge and experiences of Piaget's developmental psychology (Piaget, 1951) Freud's psychoanalysis (Freud, 1938) with Lorenz's work of imprinting goslings (Lorenz, 1981) and Harlow's research (Harlow, 1971) to develop a theory of attachment that has withstood the critics through the years and has come into its own as a reliable and empirically valid theory.

Bowlby concluded there was an **innate** need for social interaction in human infants that eventually became focused on a specific figure (Lamb, Thompson, Gardner, & Charnov, 1985). Harlow's findings on contact comfort (Harlow, 1971) suggested that this need might be best satisfied by physical contact with an adult.

The evolutionary biological model that emerged emphasized the importance of natural selection in shaping the behavioral repertoire of any species - eliminating behavioral patterns that did not promote species survival as

well as spreading through the population those behaviors that enhanced species success (Lamb et al. 1985). The behavioral patterns of sub human species include locomotion, clinging, and grasping to meet the needs of protective proximity. However, for human infants, who are virtually helpless at birth, these behaviors are only in vestigial form lacking in both strength and maturity. So for the human infant other proximity seeking behaviors (Schaffer & Emerson, 1964) must be present. Signaling becomes a most important behavior at that time. The human infant uses signals such as crying and smiling when seeking proximity to a specific figure. The way in which these signals are responded to will determine the amount and strength of the attachment of infant to adult. Thus infants become securely attached to individuals who consistently and appropriately respond to the proximity seeking signals. As infants are equipped with care-eliciting behaviors so are adults equipped with care-taking responses. These complimentary behaviors, when functioning correctly, serve to attach the infant to the adult and the adult to the infant (Lamb, 1982). Both of which are necessary if true attachment is to be achieved.

Attachment theory also suggests that the degree of proximity needed will vary over time but the degree of 'felt security' (Sroufe & Waters, 1977) will not vary. As infants get older their proximity needs usually expand.

Their parameters become larger which allows them the freedom to explore as long as the adult is within those parameters of security set by the children. This felt security is constant unless acted upon by an outside force.

The Development of Attachment Bonds

Bowlby (1969) proposed that there were four stages to developing attachment bonds. In the first stage, **orientation and signals without discrimination of figure**, infants pre-attach to anyone who satisfies their needs and responds to their signals. At this point the infants cannot discriminate among individuals. However, as this stage progresses, the infants become aware of differences in individuals and begin pre-attaching to the individuals with whom they have had the most contact (Winnicott, 1987).

The second stage, **orientation and signals directed towards one or more discriminated figures**, shows a marked increase in preferences for a small number of especially familiar individuals such as the immediate family (Bowlby, 1969; Ainsworth et al. 1978).

The first real attachment bonds seem to occur during the third stage, **maintenance of proximity to a discriminated figure by means of locomotion as well as signals.** This transition is marked by the emergence of separation protest from their attachment figures (Schaffer & Callendar, 1959; Yarrow & Goodwin, 1973). Separation protest is the infant's

attempt to summon the attachment figure back into proximity. This represents the infant's awareness that the adult continues to exist even when not visible, audible, or palpable. The cognitive capacity to understand this existence represents the onset of real emotional attachments (Lamb et al. 1985).

The final transition occurs when these children can recognize that others (their attachment figure) have desires and needs of their own which have to be taken into account when interacting with them (Marvin, 1975). Bowlby (1969) refers to this stage as **formation of goal corrected partnership.**

As attachment theory has evolved, several assumptions have been addressed by both Bowlby and Ainsworth. Through research and studies, these assumptions have become an integral part of the theory.

Assumption One - A Need for Attachment

Attachment theory regards the propensity to make intimate emotional bonds as a basic component of human nature (Bowlby, 1988). For infants, it is natural to look to a caregiver to meet their needs. These needs include food, comfort and support in adversity. There is also an emotional need which seeks pure emotional togetherness (M. Meyers, personal communication, Feb. 16, 1991). This is the loving type behavior such as touching, holding and smiling

other than when the physical needs are being met. It is this emotional togetherness that assures the children that the caregiver is steady, dependable, and is going to be there for them (Karen, 1990). It takes a willingness of both the careseeker and the caregiver to allow this attachment to occur. This type of attachment also insures that the infants will be at least minimally capable of forming satisfying relationships and of passing that ability on to their children (Bowlby, 1988). If this attachment is not achieved consequences ranging from mild to severe can occur. On-going studies are revealing that unattachment is one of the primary causes of rapidly increasing crime, particularly in children (Magid & McKelvey, 1989). Even if this lack of attachment doesn't emulate itself in crime the unattached children are likely to exhibit unacceptable behavior which can render them as unacceptable individuals creating many difficulties throughout their lives.

Second Assumption - Psychology of Relatedness

In the study of any science, the question arises concerning empirical data. Ainsworth provided empirical evidence, through her Strange Situation Studies for a number of conclusions that had only been intimated (Karen, 1990). This proof enabled Bowlby to synthesize his thoughts and hypotheses with Ainsworth empirical evidence and develop his attachment theory. Ainsworth believed there was a

psychology of relatedness and through her efforts enabled psychology to look at the emotional development of children in a reliable, quantifiable way. Previous to this, developmental psychology had a basic cognitive approach with emphasis on the functions as abstraction, memory and perception (Piaget, 1951). Attachment theory holds that emotional development is the cornerstone to other types of development and plays a part in each developmental level (Lamb, et al. 1985).

Third Assumption - The Parent as a Secure Base

This assumption was derived from Blatz's Security Theory (Blatz, 1966). Attachment theory incorporates the idea that children gain security from being near their parents and that security enables them to move out to explore their world, to learn about it and to acquire the skills to master what they encounter out there (Blatz, 1966). The secure feeling that being close gives is postulated as originating in the womb where an infant physically is surrounded all of the time. (Curtis, personal communication, Dec. 3, 1990). This desire to be surrounded or physically close remains with the infants after birth and basically throughout their lives. Ainsworth, et al. (1978) through observations, looked for this surroundedness behavior when the mother and infants came into the laboratory. Two of her episodes addressed the questions of

how far away from the mothers the infants would explore and what would be the reaction if the mothers left the room. She grouped her findings into three categories. First, the infants that would explore the room while keeping occasional eye contact with their mothers (using her as a base) while she was in the room and cry when she left and greeted her with pleasure when she returned, were labeled as **securely attached** (Ainsworth et al. 1978). These infants had learned that even if their mother left she would eventually be back. This type of attachment stretches over distance and time.

The second category was comprised of infants who were clingy all of the time and upon separation from their mothers cried profusely. When the mothers returned the infants would seek contact with her and at the same time arch away from her, resisting to be comforted. Ainsworth labeled those infants as **insecurely or anxiously attached** (Ainsworth et al. 1978).

Ainsworth's third category included infants who seemed to be very independent. They explored the room but did not initiate any eye contact with their mothers, as if they were not there. When the mothers left the room the infants did not seem to be affected and upon their return the infants avoided the mothers. These infants were labeled **avoidant attachment** (Ainsworth et al. 1978). These findings as well as Harlow's Rhesus Study (1971) demonstrated that attached

infants seek a secure base, a continuation of the surroundedness feeling they experienced in the womb.

Fourth Assumption - Association of Attachment Styles and Parenting Styles

Using Robertson's style of research, direct observation in a natural environment, was what made the Strange Situation the significant study that it was (Bowlby, 1973). Ainsworth's team observed the infants and their mothers in their homes prior to observing them in the laboratory situation. With those observations, Ainsworth was able to make specific associations between the infant's attachment styles and parenting styles (Ainsworth et al. 1978). Ainsworth found that mothers of securely attached infants responded very readily to the needs of their infants, including the emotional needs of love and affection. Mothers of anxiously attached infants were inconsistent and unresponsive and the mothers of avoidant infants were distant and stand offish (Ainsworth et al. 1978). These findings changed the perceptions about infancy and child-rearing which began debates that are on-going even today (Karen, 1990).

Attachment theory is one approach to the understanding of early social and emotional development. Much of the behavioral research is concerned with demonstrating at how early of an age infants are both competent and sensitive to

environmental input (Lamb et al. 1985).

Kagan, A Differing Point of View

Jerome Kagan, a psychologist at Harvard University, believes that too much attention is being paid to the early experiences of children, arguing that children are much more resilient than adults tend to think (Kagan, 1989). Believing that genes play a large part of what children become, he rejects the idea that parenting has a significant impact on what a children will become as they grow to adulthood (Kagan, 1989). Kagan also argues that attachment is popular because of the times, not because it has any empirical value and he goes on to say people like it because it is so commonsensical (Karen, 1990). However, Kagan affirms that just because it is intuitive does not mean it is right and in psychology intuition is often wrong (Kagan, 1989).

Evidence of the Problem

Attachment disorders have been in evidence for many years but the label as a popular diagnosis is relatively new. Dr. Foster Cline founded the Attachment Center at Evergreen in 1972, however is was almost ten years later that the diagnosis of attachment disorders was accepted by the public as well as professionals (Attachment Center, personal communication, Feb. 5, 1991). Residential treatment centers and their waiting lists seem to be

overflowing with children and adults who fit into this category. Schools, also are beginning to recognize that many of their behavioral problems, which tend to use a great deal of time and energy, are coming from attachment issues. These attachment disordered children do not seem to fit in to the regular classroom or the special education classroom (Fay, personal communication, February 26, 1991). For the most part, they are bright but tend to act out, bully, frighten or even harm other children at the school. Safety can become a real factor in those situations.

Along with residential treatment centers and schools, communities are beginning to see a rise in the number of children who are being put into the CHINS program (children in need of supervision). These are children who have become incorrigible at home, in school, and in the community. When these children are evaluated many of them seem to exhibit the symptoms of being unattached (Lynch, personal communication, January 25, 1991).

Foster home programs are finding that these unattached children cannot be cared for with the average or even above average parenting skills. These children cannot change just by giving them 'a little more love' (Magid, 1989). They are being bounced around from foster family to foster family with no chance of building any type of relationship. Unattached children have been known to be placed in up to nineteen different homes where placements did not work out

(Rayfield, 1990). This scenario sounds like these poor children are being bounced around at the whim of the foster parents, which is untrue and unfair to the foster parents. Most of these children exhibit behaviors that are intolerable, such as; starting fires, hurting or killing pets, inappropriate sexual behavior to self and other children in the home, and hurting or killing other children (Rayfield, 1990). How many individuals would welcome a child who exhibited these behaviors into their home indefinitely?

For the adoption agencies the 'return to sender' phenomenon is growing out of control (Sachs, 1990). In looking at that phenomenon it is being discovered that many of the children being returned are a result of unsuccessful bonding with the primary caregiver or any caregiver previous to the adoptive parents. These children do not possess the skills or the desire to bond with adoptive parents. Many adoptive parents have tried to develop a bond with the child but are being overwhelmed by unexpected problems (Harlow, 1989). While adoption agencies claim there can be no warranties on adoptions, adoptive parents argue that there must be some sort of method to reduce the instance of 'wrongful adoptions' (Sachs, 1990).

During the last three years, organizations, parent groups and treatment centers have appeared at a significant rate. According to ATTACh (Staff, 1988), Association for

the Treatment and Training in the Attachment of Children, these organizations, whose membership is primarily attachment professionals, promote the identification and effective intervention and treatment of individuals with attachment disorders (Staff, 1990).

Parental groups have also been in evidence around the country. These groups provide information, advice, personal experiences and a network with which group members can interact and be of support to one another (Trenberth, 1990). Parents are beginning to share horror stories, about their children who are being diagnosed as unattached, and are discovering that there are many people who are experiencing the same difficulties.

Treatment Centers are beginning to specifically address attachment issues and opening clinics with **attachment** being the sole specialization of the clinic as in 'The Attachment Center and Forest Heights Lodge' both of Evergreen Colorado.

CHAPTER FOUR

THE ATTACHMENT MODEL

One currently held view about emotionally and behaviorally disordered children is that these children are reflecting attachment difficulties (Curtis, 1985). To better understand how these difficulties can arise, one should first look at how normal attachment occurs.

Newborn infants are totally dependent on others for their survival. Each time the infants have a need they become uncomfortable and express this by crying and increased motor movements. With each need filling response from caregivers, the children buils an increasing **trust of caretaking** (See Appendix). In addition to meeting the children's physical needs, caregivers also provide a great deal of nurture or social interaction, such as touch, speech, eye contact and rocking. These nurturing behaviors are as crucial as meeting the children's physical needs. And without them children can be emotionally, physically, and intellectually retarded or even fail to survive.

As the children grow and develop, they have an ever increasing mobility that allows them to interact independently within their environment. Dangers to the

children, as well as social expectations, require a limiting and redirecting of their actions. The children's first response to such restrictions is a rage (the classical two-year-old tantrum). Gradually they recognize the benefit to both themself and others when they cooperate. A healthy independence develops, and they begin making choices within responsible limits set by others. The children have a **trust of control** by others (See Appendix).

The primary disciplinary tool that is used during the child's growing independence is variations in nurture. When people are pleased they smile, praise, caress and cuddle the child. When people are displeased they use negative variations of nurture such as a frown and a rough voice.

As the children grow older, they begin to have the values of the caregiver within themselves. They are now telling themselves 'yes' and 'no'. In addition, the children have internal feelings in response to doing right or wrong; doing good feels good and doing bad feels bad. The children have the beginnings of a conscience, a **trust of self** (See Appendix). These three levels of trust, trust of caregiving, trust of control, and trust of self, are the basic elements of attachment. The children have a lifelong bond to other human beings. This bond becomes the basic building block of human relationships and is essential to friendship, marriage, parenting, work relationships and a meaningful, moral participation in society (Curtis, personal

communication Dec. 3, 1990).

Attachment Cycle Disrupters

There are many things that can occur in a child's life that may disrupt the development of a normal attachment. These disrupters are the consequences of 'breaks' which happen, usually, in the first year of life (M. Meyers, personal communication, Feb. 16, 1991). The extent of the pathologies depends on factors like age, ego strengths, the child's genetic strengths and the length of time the cycle was broken. It is the failure to reach these milestones that puts children at high risk of developing unattached behavior patterns. It is the first year that is of the greatest importance for developmental stages (Magid & McKelvey, 1987). It is possible however, for attachment breaks to occur in subsequent years even if proper attachment has occurred.

Attachment cycle disrupters include prebirth and birth factors, learning disabilities, physical handicaps, parenting factors, and trauma (Curtis, 1988). Each of these areas will be addressed in the following paragraphs.

Prebirth and Birth Factors. Some children enter the world with conditions that prevent them from experiencing caregiving in a manner which promotes healthy attachment. Some children are born with sensory or stimulation difficulties which result in normal care being unpleasant or

even painful to the child. The children thus recoil from care. It can become so physically painful for these to be close to anyone or anything that may stimulates their senses, that the only thing the they can do is to distance themselves from 'the world'. There is a growing thought, according to Ray Curtis (personal communication, Dec. 3, 1990), Forest Heights Lodge Director of Social Services, and Dr. Martha Welch (1987) that autistic children suffer from this same type of sensory or stimulation difficulty and autistic children are known to have very little if any attachment to other individuals. Another birth factor, which is relatively new is the babies that are born with drug addictions or diseases such as AIDS or FAS (Fetal Alcohol Syndrome) that cause them stay in the hospital for an extended period of time. The hospital care is usually one of just taking care of physical needs of these children. That is not to say that the hospital personnel do not try to nurture these children but the number of children that they must care for makes it difficult for real bonding to take place. (Curtis, 1988).

Learning Disabilities. Because of learning disabilities, some children do not experience or understand the world like most children (Fraiberg, 1977) The anxiety and confusion about this world, and more importantly their misperception of care given to them, can result in a failure to develop the crucial levels of trust. These children,

often, do not perceive a constant type of care as the same each time, even though the caregiver is doing it the same each time, therefore the children will distance themselves because they feel that they cannot count on the caregiver to be consistent (Curtis, 1988).

Physical Handicaps. Much like learning disabilities, physical handicaps can cause childrem to experience care in a distorted manner. For example, deaf or blind children need alternative kinds of care to compensate for part of the caring experience that is lost through their handicap. Many times months go be before the handicap is discovered, or when it is discovered there is limited understanding of the kinds of compensatory care necessary to facilitate a normal attachment (Curtis, 1988).

Parenting Factors. First it must be recognized that no one is fully prepared for the task of parenting and there are many circumstances in the life of a child over which no one has control. Anxious, uncomfortable caregivers cause the children to experience a world that appears unsafe and harder to trust (Winnicott, 1987). Parents who came to the task unprepared or who are under many other forms of stress, can be very anxious in their attempts to do what is best for the children.

One phenomenon which is unfolding at a frightening pace is teenage pregnancy. There are about 1.3 million children living with 1.1 million teenage mothers. More than

half of these are living with unmarried mothers and two-thirds were born to mothers seventeen or younger (Magid & McKelvey, 1989). These children are perhaps the most critical of high risk babies (Fraiberg, 1982). The problems faced by these teenage mothers and their children are numerous. Teenage mothers often do not receive prenatal care. Without this care and guidance the teen mother is likely to maintain a poor diet and poor medical care which can lead to low birth weight babies who are at increased risk for serious mental, physical, and developmental problems. Teenage pregnancies also breed school dropouts and poverty. These young mothers tend to not stay in school and therefore will not be able to earn as much as someone who graduates from high school. Also the art of mothering is not inborn. It is a learned process. Many teenage mothers of today have not learned this process yet. They expect this child to be like a play toy that they can play with or put away at their choosing (M. Meyers, personal communication, Feb. 16, 1991). Often grandparents are involved in raising these children and the children become confused as to with whom they actually belong. This situation creates a great lack of stability for the child and often this lack will cause the children to distance themselves from all caregivers (Fraiberg, 1977). Another disaster that can occur with teenage mothers is that of inflicting abuse upon the children. These mothers are often

so frustrated with their children, because of their own ignorance of how to handle them, that the only alternative these mothers see, because of their lack of maturity, is to lash out at the children. This abuse causes a break in the developmental cycle which often leads to unattachment (Curtis, 1988).

Care by parents who are attempting to structure carefully what they do for their children can be overly rigid. If care is more by schedule than by the interactions of demand and response, the children have greater difficulty trusting that their needs will be met by the caregiver.

Unpredictable care means that children do not experience a consistency that allows them to develop a high level of trust that their needs will be met. Family crisis, illness, a series of moves, or frequent changes in babysitters, can disrupt a consistent pattern of care and the type of care received (R. Curtis, personal communication, Dec. 3, 1990).

Trauma. A harmful incident or series of incidents can occur in the lives of children. Illness or accidents, which are experienced by the children as painful and through which they perceive the parents as failing to protect them (no matter what the parents may have done), can result in the children losing trust. For some children, a hospitalization can feel like abandonment. Family problems can disrupt a comfortable parent-child relationship. Frequent moves,

unemployment, financial hardship, illness, or death of a family member can dramatically change the previously healthy attachment patterns. Often parents are unaware of what their children are experiencing, or they do not know how to help the them through the experience.

Another traumatic situation that can cause a break in attachment is that of divorce. Divorce causes uncertainty about the continued availability of the mother or the father. This uncertainty destroys the ability to trust others. However, previous research has shown that the conflict-ridden intact family is more deleterious to family members than stable home situation where the parents are divorced (Heatherington, Cox, & Cox, 1978). The question then becomes, is the single parent home a stable environment? Sadly, the answer today is more than often no. According to Dave Chapman, Albany County School case manager, one of the biggest contributors to attachment disorders today "is the style of living that these children are subjected to" (personal communication, February 9, 1991). The widespread practice of moving in and moving out on a whim as the opportunity avails itself, leaves children confused, anxious and overwhelmed wondering who will be in their lives tomorrow, if that person will really want them, is this home going to be the last one, a stable one and just what lies ahead for them? If the stability is demolished the children usually unattach because it is so painful to

keep having their attachments broken by the numerous moves (M. Meyer, personal communication, February, 16, 1991).

Foster care is also an example of an attachment disrupter. It involves changes in quality and type of care. These changes inhibit the attachment process by not allowing the caregiver to be constant. Foster care is temporary and often the children and the caregiver know that. In addition, there are many problems with administration, funding, staffing and service delivery which affect the foster care system. Horejsi (1979) discloses that a growing number (possibly 40%) of children in foster care have physical, emotional, or mental handicaps.

Sometimes the children, if old enough, figure out that they are not going to be in one place very long so they distance themselves so they will not have to go through the painful process of leaving the caregiver (Allison, 1984). Foster children can also experience a separation reaction (Bowlby, 1962). Depending on the age and circumstances of placement the child may experience a mourning period (for the natural parents), and shock in which the children appear to be docile and display very little emotion. Eventually, the children progress through these separation stages and begin to understand the placement and comes to terms with it. However, if children do not progress or regress they may become a difficult foster children with attachment problems (Horejsi & Gallacher, 1977).

ADOPTION

Adoption holds another difficult experience for some children. Bureaucratic delays cause children to hang in the balance for months and years. These children do not form any real relationships or attachments they just exist in limbo, often until it is too late to change that emotional existence.

Recently, many parents have adopted special needs children. One program that promotes this type of adoption is 'Wednesday's Child' (Hollingsworth, 1988). The Wednesday's Child program is popular because adoptive parents have seen this as a easy adoption as well as a challenging one. However, these adoptive parents are discovering that they cannot handle these children and that perhaps some of Wednesday's Child is full of woe (Jarboe, 1988).

One reason that these adoptions encounter distress is because the adoption laws that do not allow the release of much of the child's history, how many foster homes he has been in and out of, whether the child has been neglected or abused and how severe, or if the child or his natural parents have a history of mental illness (Harlow, 1989). Without this information the adoptive parents do not have a clue of what to look out for. They must discover what the problems are on their own which can take years (Harlow, 1989). And while they are trying to figure out the problems

these children are usually regressing and getting worse.

Another set of circumstances in which adoptive parents can get into difficulty is adopting a children who they believe to be normal with no history of any type of problems. These parents are unexpecting victims who are now beginning to give their adopted children back to the agency or state (Sachs, 1990). The controversy again, is what information is allowed to be or desired to be released to the adoptive parents before the adoption. There is a growing movement within the adoption community to push for legislation that will allow the release of a complete history, to open the records (with the exception of the birth parents names) to the adoptive parents (Staff, 1989).

In Foster Cline's practice, a well-known psychiatrist and authority on unattached children, two-thirds of the sociopathic youngsters he sees in treatment for bonding difficulties are adopted children (Magid & McKelvey, 1987). It seems as if there is an inappropriate number of unattached children coming from adoptions and foster care.

The Day Care Issue

This issue has become very controversial recently. Both sides are well represented as well as very emotionally charged. According to White (1985), Belsky (1986), Magid & McKelvey (1987), Cline (1979), Fraiberg (1977), Bowlby (1951) and Meyerhoff (1984), infant day care can be

detrimental to an infant's developmental process. Belsky and Rovine (1988) found that twenty or more hours of alternative care per week was associated with significantly increased risk of the development of insecure infant-mother attachment relationships. However, believers in day care cite several empirical studies Kagan, Kearsley & Zelazo (1978), Cornelius and Denny (1975), and Portnoy and Simmons (1978), whose findings indicated that day care children were no more anxious and insecure than home-reared children (Zigler & Gordon, 1982). Some questions remain about the effects of day care on the security of toddlers' attachment. Many of these studies admit limitations such as the day care center was utopia-like with low enrollment, constant staff members, very high standards, and there were no very young infants studied (Maynard, 1985). Those limitations allow critics of day care to question and refute the findings. Fraiberg professes that

> we do not need to prove that such programs can be damaging to many children. When a child spends eleven to twelve hours of his waking day in the care of different custodians, no parent and no educator can say the child's development is being promoted or enhanced and common sense tells us that children are harmed by indifference (1977, p. 87).

She is joined by Meyerhoff who states that

> there is little doubt that any intellectually honest person who has reviewed the research on early childhood development or who has worked with parents and babies would not be concerned about the growing trend towards placing infants and toddlers in substitute care for eight or none hours five days a week (1984, p. 2).

Two recently completed research studies support the premise that too early day care can be harmful to infants. Schwartz (1986) reported that infants in fultime day care displayed more avoidant behavior than did those in part-time day care or home care and Blesky (1987) whose findings put fultime day care children at risk of heightened aggressiveness, non-compliance and withdrawal.

As research continues on this issue, McCartney and Galanopoulos (1988) have developed a straight forward ecological model for considering the relationship between attachment and child care. It is hoped that this model will become a guideline for future research.

One thread that seemed to be constant in the day care literature, whether for or against day care, was the idea that day care is an institution that is here to stay, it won't go away and since it is here to stay, all involved individuals must work to improve the system (Blum, 1983).

Unattached Children

When children fail to develop an attachment a number of symptoms emerge. All or some of these symptoms can be present in varying degrees of intensity, depending on the severity of the circumstances that led to the disruption of the attachment (R. Curtis, personal communication, Dec. 3, 1990).

The symptoms will be presented in table form. Table 1 lists each symptom, an explaination of the symptom, and a true example of way in which the symptomatic behavior was displayed. The information in the table was synthesized through the works of Magid and McKelvey (1987), Magid (1989), Cline (1979), Curtis, Meyers, Fay, and Chapman (personal communications, Dec. 1990, Jan. and Feb. 1991), Trenberth (1989, 1990), and Staff (1988, 1989, 1990). The personal anecdotes were contributed by parents and therapists who wished to remain anonymous. These individuals provided their information through personal communications (Jan. and Feb. 1991).

Table 1

Symptoms of the Unattached Child

Symptom Lack of ability to give and receive affection

The child purposely distances himself from the caregiver by refusing to be touched or voluntarily touching anyone else because he does not want to be hurt physically or psychologically.

Example

"To hold Jim, I had to wrap him so tightly in a blanket that he could not get his arm out to grab the chair and pull himself free from me". (Magid & McKelvey, 1987, p.81)

Symptom Superficial attractiveness and friendliness with strangers

The child is a manipulator who can look cute, loveable, and helpless. He is able to take advantage of others easily, by twisting events to suit his own purposes.

Example

"Chris' eagerness to leave his foster parents for two virtual strangers coupled with his behavior, which we finally realized was manipulative made Chris a difficult child. (Harlow, 1989, p. 18)

Symptom Preoccupation with blood, fire, and gore

The child will draw bloody, gory pictures, profess evil, and frequently start fires. These behaviors channel his rage and anger. It also gives the child a feeling of power and control, especially if people then become afraid of the child.

Example

"The kind of pictures we found around the house all looked like the devil with blood oozing from all over the body. His face had the same cold eyes that James had. He also tried to burn us all up in the house". (Anonymous, 1991)

Symptom Cruelty to others especially pets

The child, very sneakily, perpetrates an incident in which someone else gets hurt. He always says it was an accident or blames someone else. Family pets can become an endangered species because the child will taunt, torture and even kill the pet. The child gets pure joy out of hurting something, because it gives him a feeling of power and strength.

Example

"We had to put an alarm on Chris' bedroom door because we were afraid he might sneak out during the night and hurt the other children". (Harlow, 1989, p.27)

Symptom Abnormalities in eye contact

The child will refuse to look anyone in the eye unless he is extremely angry or manipulating to get something he wants. The child may exhibit 'motor eyes', eyes that never fix on one thing. He hides his feelings so he won't appear vulnerable and cannot be hurt.

Example

"I had even gotten out of my chair to try to catch her eyes but she would not stop even when I requested that she look at me, it was an impossible situation". (Anonymous, 1991)

Symptom Abnormalities in speech patterns

The child will talk baby talk, slur, mumble words or talk very low unless angry, at which time, he will scream using developmentally correct words.

Example

"Melissa, a third grader, constantly talked baby talk or mumbled her words to get me to say 'what?' or 'please say that again'. I tried and tried to correct her speech to no avail until one day she got extremely angry with me and seemed to have no problem shouting all her words correctly". (Anonymous, 1991)

Symptom Crazy lying

The child lies even when he is caught red-handed or when it does not make sense to lie, it is just blatant behavior. This type of lying reinforces the child's belief that he does not care what anyone else thinks of him (again, no conscience).

Example

"I told him to stop punching his little brother in the mouth and he actually denied he was doing it. However, he was sitting on top of his brother with his hand poised to hit again". (Magid & McKelvey, 1987, p. 198)

Symptom Stealing, hoarding and gorging

The child will steal, hoard or gorge, especially food. He will rarely eat or use what he takes he just stockpiles it. The child is trying to fill an emptiness he feels inside.

Example

"We locked every food cupboard in the kitchen after each meal but that did not stop John from breaking in, getting the food and taking it to the closet. It did not seem to matter that he had a drawer in the kitchen stocked with all his favorite foods and at his disposal. He wanted what belonged to the rest of the family. It was like an obsession to him". (Anonymous, 1991)

Symptom Lack of long-term friends

The child is often the bully of the playground exhibiting manipulative, cruel behavior. No one wants to be around him much less be friends with him. The child feels like he is very much in control and he rules wherever he goes.

Example

"Kenny had no friends. On rare occasions, when he was not being punished, he would go outside and be involved in hassles and scrapes. He refused to wait his tern and would bully others". (Fahlberg, 1990, p.26)

Symptom Extreme control problems

The child will constantly test and bait to see what kind of reaction he will get. He will also push to the limits when acting out. He wants to believe he is in control so he tries to push others out of control.

Example

"Nancy marched into the room which was full of strangers and announced that 'last week, Kenny took me down stairs and pulled my pants down and played with me!' Then she marched over to the sofa and sat there with a smug look on her face, a definite 'I gotcha' grin. (Cline, 1979, p. 106)

Treatment of Attachment Disorders

Parents and professionals responsible for seriously disturbed children are confronted with a number of treatment options (Fahlberg, 1990). The decisions made may have a lifelong impact on these children so such decisions should be accompanied by concern, thought, anxiety and detailed exploration of options. The goal is to find the treatment that best meets all of the needs of these children (M. Meyers, personal communication, Feb. 16, 1991; Cline, 1979; Reid, 1985; Fahlberg, 1990).

When investigating treatment options, the most important factor to consider is the severity of the attachment disorder. On a continuum of attachment disorders (See Figure 1), severity can range from mild, with minimal symptoms to extremely severe requiring psychiatric hospitalization. The points along the continuum increase in the strength of treatment options as the severity of the disorder increases. Through testing and evaluations professionals can discover the severity and place the child into the appropriate treatment setting.

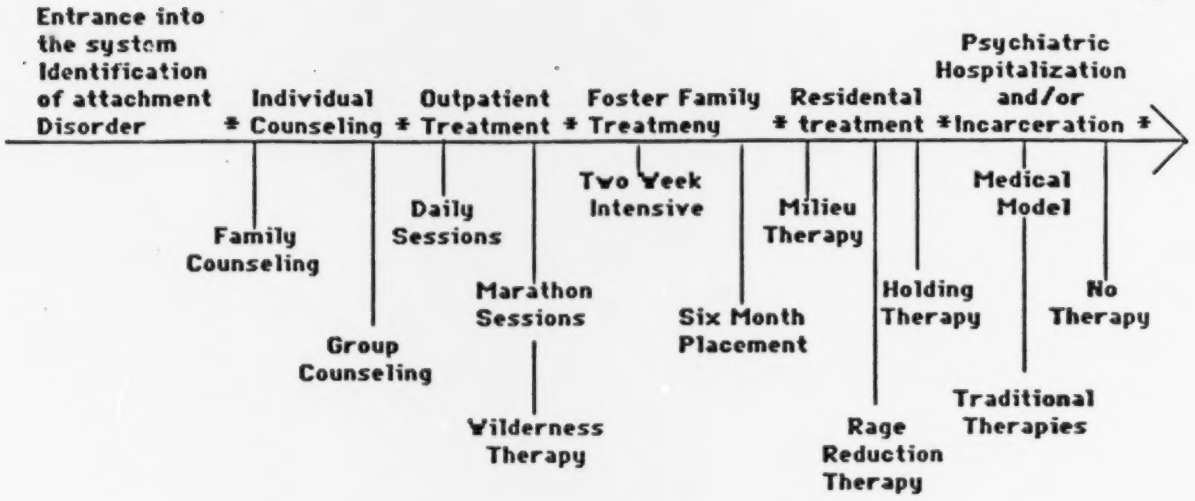


Figure 1. Treatment Continuum for Attachment Disorders

The child enters the system through referrals most commonly, from parents or school personnel. Psychological testing and evaluation is used for identifying the children with attachment disorders.

The evaluation will reveal the seriousness of the disorder and the children will be placed in the appropriate treatment option. If the treatment option is successful the children will be phased out of the system, however, if the option proves ineffective the children will continue in the system, progressing through the treatment options as is indicated by the severity.

In examining the continuum, the least severe treatment option is personal counseling with a heavy emphasis on family involvement. Both Chapman and Meyers (personal communication, Feb. 1991) concurred that family involvement is essential for a successful therapeutic outcome. The family must be supportive, understanding and be able to experience the therapy and the results with the child. "They **all** need to grow to facilitate change" (M. Meyers, personal communication, Feb. 16, 1991).

Along with personal counseling and family counseling group work is suggested. This is only after the children have progressed successfully in individual counseling. It is believed that a group experience could allow the children the opportunity to see how others attach and to put the them in a safe atmosphere in which they can attempt new attachment behaviors.

For children who are identified as fitting into a more severe group the next point on the continuum is an out patient treatment program. This type of program includes daily therapy sessions as well as marathon activities. In daily therapy the children are expected to attend and participate in the treatment in a on-going and consistent basis. The 'structure', according to Cline (1979) is the basis of this therapy. Marathon activities have included an innovative program, 'Wilderness Therapy'. Magid and McKelvey (1987) explain that this therapy gives troubled

youth a chance to test themselves against the elements and learn about their inner feelings in a totally new environment. The children (who must be old enough to physically handle themselves) are expected to meet the challenges of the outdoors and then be able to generalize their experiences into their everyday lives (Staff, 1990)

Aspen Achievement Academy, Colorado Outward Bound, Kent Mountain Adventure, Vision Quest (mostly court appointed), and Wilderness Conquest (personal communications, Feb. 1991) believe the Wilderness Therapy can and does greatly increase the child's chances of becoming a productive citizen within his community. Conrad Boeding consultant to Evergreen Consultants in Human Behavior and to the Attachment Center, strongly recommends a wilderness experience as it gives the children a chance to experience success so that they get the idea that they can overcome anything. It allows a positive experience so they can say "I did it! I can work on my own and I did not die, maybe I can do other things I do not think I can do" (Staff, 1990).

The third step on the continuum is Foster Family Treatment. This treatment is for children who are on the verge of severe disruption and who have not made progress in out patient programs. The treatment involves the children, their families, a primary therapist, psychiatrist and a therapeutic family. They all work together in a two week intensive session to ascertain behavior patterns of the

children, issues and intensity and frequency of control battles. With this information the therapeutic family takes these children for at least six months and works with them on their problems as well as models behavior patterns and gives the children insight into an attached family. The Attachment Center at Evergreen uses this model extensively as it believes that the program is effective and often keeps the child from being placed in longterm residential treatment or hospitalization.

If, through assessment of the children's functioning in various aspects of his life, family, school, peer relationships, community and outpatient therapy, it becomes apparent that the children need more intensive services then other placement alternatives must be addressed. The first of which is long term residential treatment at an appropriate facility, one which can best meet the identified needs of the children (Fahlberg, 1990).

Residential treatment can provide all the necessary services of daily living in addition to re-learning experiences and intrapsychic therapy. The children are cared for twenty-four hours a day, seven days a week by professionals on staff (R. Curtis, personal communication, Dec. 3, 1990). These professionals include experts in the areas of psychology, psychiatry, social work, education and medicine. Most residential treatment centers utilize the concept of milieu therapy of which the premise is that only

a total transformation of the environment over an extended period of time can lead to a lasting change (McCord, 1982). This type of therapy also allows all areas of treatment to be coordinated into one program, under one roof (Fahlberg, 1990).

As Curtis describes it, "residential treatment can teach children how to let go of the angry controlling person inside, how to have 'fun' and generally, how to be seduced by the joy of life" (personal communication, Dec. 3, 1990).

Several types of treatment are presently being used in residential treatment for attachment disorders. One fairly controversial treatment is 'rage reduction therapy'. Some professionals believe that it is adversarial in nature and therefore defeats the purpose of therapy (R. Curtis, personal communication, Dec. 3, 1990). Others believe that while it may be a radical treatment, attachment disorder is a radical problem (Magid & McKelvey, 1987). Basically, rage reduction therapy involves the physical holding and stimulation (rib tickling) and control of the patient who is confronted with a death grip resistance to accepting love and acting responsible. The therapy contains explosive dialogue as the patient is encouraged to work through unbelievable rage and anger while being forced to accept another's total control (Magid, 1989; Cline, 1979).

According to Cline (1979) most children do not need

such a severe treatment procedure but for the ones that do it enables them to find inner peace and joy.

For those clinitions who do not believe in rage reduction therapy, a modified version can be used. Holding therapy, as it is called, employs the same technique as rage reduction but without the physical stimulation. The child, while being held, is encouraged to talk about, probe and question the behavior during previous specific episodes (Fahlberg, 1990). While this therapy does not net such dynamic results as rage reduction its overall use is much greater and with less a risk to the child.

The last and most severe step on the continuum is psychiatric hospitalization and incarceration. Children who have not been successful in any other treatment usually find their way into the judicial system where they are then remanded to a psychiatric institution (Reid, 1981). The task of a psychiatric institution is to establish control of the patient because without some external reason for remaining in this anxiety-producing environment, the patient would quickly leave. "Forced or coerced treatment, for example, treatment mandated by court is preferable to voluntary hospitalization" (Reid, 1985, p. 835).

This hospitalization utilizes a combination of individual and group psychotherapy, family therapy, behavior modification and extensive drug therapy. Magid and McKelvey (1987) state that the psychiatric hospital type of therapy

(using the medical model) hasn't been very successful in treating in general, antisocial personality disorders and specifically attachment disorders citing both behavior modification and drug therapy as inappropriate for these disorders. Reid (1985) agrees saying, that general psychiatric hospitals are inappropriate for antisocial syndromes. However, Reid does believe that for the safety of the public, placement must be made in certain cases. Possibly those hospitals are just becoming holding tanks for patients that nobody wants instead of treatment facilities with appropriate and successful treatments.

Along with psychiatric hospitalization, there is a possibility of incarceration within the penal system. Many APD individuals eventually get in trouble with the law and end up in prison which can become the end of the line for them (Magid, 1989).

It is imperative that appropriate diagnosis be made so effective treatment can be given to problematic children. Each of these treatments, if handled appropriately, can realize a certain degree of success. One factor that seems to be constant in the success rate is the age of the child. The younger the child is the better chance he has to be successful in treatment (Fahlberg, 1990).

CHAPTER 5

DISCUSSION

A Proposed Model for Identifying and Dealing with Attachment Disordered Children Within the School Setting

When reviewing the aforementioned continuum, two questions come to mind. First, does the public school system have any responsibility to treat these children? And second, if so, then where on the continuum does public school reside? The author's thoughts are that the school does have a responsibility to all children including children who have attachment disorders. According to PL 94-142 (Valente, 1980) each child has a right to a quality education in the least restrictive environment. In addition to the law, the author believes that public school has a moral responsibility to the students and to society as a whole. The product that public education produces is the next generation who will be facing a multitude of new problems and will need a mentally healthy society in which to operate.

Public school should occupy a point at the beginning of the continuum where the severity of the disorder is minimal. There are many children that exhibit attachment

disorder characteristics who are never identified and they just continue to get worse. Involving the school would allow another opportunity for those children to be identified and appropriate treatment to be administered. Lack of attachment seems to be a progressive disorder in which successful intervention is necessary to prevent the child from moving along the continuum and eventually requiring residential treatment, psychiatric hospitalization or incarceration.

With appropriate knowledge and awareness of this disorder, the public school is most apt to identify the child who is mildly unattached.

The author does not advocate that public schools become independent treatment agents for children with attachment disorders, however, it is believed that the school can become part of a team that will help attachment disordered children.

The following proposed model introduces a baseline for intervention which, if successful, can alleviate the problem or will at least bring the problem to an awareness level so other interventions can be recommended (See Table 2).

Table 2

A Proposed Attachment Model for the School Setting

Step 1.	Precipitating Behavior
	Inappropriate acting out behavior that seems to continue
Step 2.	Conference With Those Involved With The Child
	Gathering information about experiences others have had with the child
Step 3.	Conference With The Child
	Gathering information about how the child sees the behavior
Step 4.	Placement Of The Child In A Group
	Observing how the child interacts with other children looking for manipulative behavior
Step 5.	Judgement Of The Child's Motivations
	Manipulative controlling behavior
	Honest interactive behavior
Step 6.	Background Exploration
	Using all resources possible including parents
Step 7.	Create a Team and Process Information
	Look for attachment disrupters and symptoms of attachment disorders
Step 8.	Build A Relationship With The Child
	Establish boundaries and trust
Step 9.	Integration Of Attachment Skills
	Generalizing the skills into other areas of the child's life

The model goes into operation usually as a result of some type of precipitating behavior. That is, inappropriate behavior or acting out behavior which is continuous and becomes disruptive inside and outside of the classroom. This type of behavior should not be confused with behavior that is exhibited one time or just occasionally. Suspect behavior is that which is continual and increases in intensity.

The second step in the proposed model is to confer with the teacher and others who are involved with the student. These conferences will enable the counselor to gather information about experiences that others have had with the child. This information can tell the counselor if the behavior is continuous and the range of severity of the behavior.

Next, the counselor confers with the child to get an idea of how the child sees himself or herself behaving. This will give the counselor an idea of the child's self esteem as well as how intentional the behavior is. If the child exhibits a low self esteem, it may or may not be an indicator of attachment problems however, it is something to keep in mind and watch. Intentional behavior can indicate a wanton desire to be disruptive and is certainly a sign of some type of problem.

The child is then put into a group where the counselor can observe the behavior without directly being involved

with the child. The advantage to this type of observation is that the counselor is better able to spot manipulation if she is observing from the outside. "Sometimes it is difficult to see manipulation if you are the one who is being manipulated" (M. Meyers, personal communication, Feb. 16, 1991). Manipulation is a strong indicator of attachment disorders and the counselor should be very aware of that fact.

Step 5 involves making a judgement on the child's motivations and actions within the group. If the child is not able to join the group without being manipulative and controlling, the counselor needs to continue in the model with gathering backgrownd information. However, if the child can join in the group without exhibiting manipulating, controlling behavior then the counselor can possibly continue with the child in the group as well as beginning personal counseling.

A background check can begin with school records and personal accounts by the teacher and others involved with the child. But, be careful about believing what could be just gossip or frustration from others.

This is the step in which the parents should become involved. They can be a very important part of the process and treatment. Through very prudent questioning and critical listening the counselor can find out a wealth of information and possibly if the parents had a history of

disrupters which could have led to their own attachment difficulties. According to Fay (personal communication, Feb. 26, 1991) this disorder feeds on itself much the same as child abuse. The abused becomes the abuser and the unattached produces the unattached. The parents can also reveal what type of disrupters the child has experienced. Depending upon what this information is, there can be many clues, symptoms and 'red flags' that the counselor needs to note when processing this information.

The parents can be a very supportive structure for the child as well as for the counselor and the others who are involved. They can carry on the same type of trust-building therapy at home that is going on at school.

Assessing the severity of the attachment disorder is a very difficult task. First, the assessors must be well-schooled about attachment disorders or know where to go to access the information. Help, such as other counselors, psychologists, psychiatrists and personnel at facilities dealing with attachment disorders are all viable options for the counselor who is dealing with the child. At this step in the model the counselor needs to create a team that will be capable of assessing possible attachment disorders. The team approach allows the pressure of assessing the child to be spread out among its members and allows a greater amount of input than one person would have. The team must also become a support system for the child especially during the

integration stage of the model.

In assessing the child, the team must arrive at one of three conclusions. The first being that the child is just exhibiting inappropriate behavior with no noticeable hurtful intent and that the behavior is not constant. Possibly this child is going through a rough time and just needs some help in getting 'over the hump'. The second possible conclusion is that the child is mildly unattached and that the school personnel can handle the child. If this conclusion is agreed upon then the counselor needs to proceed with this model. The third conclusion would be that the child needs more help than the team and the school setting could offer, wherein the team would need to recommend another treatment option immediately.

If the child remains in the school setting the counselor would then begin to build a relationship with the child. The counselor must 'go slowly and tread lightly' in order to establish both trust and boundaries. This step can be the most difficult part of the model as well as the most rewarding part. Building this relationship will require the use of good counseling skills along with a great deal of patience.

The final step, (Step 9), of this proposed model is for the child to integrate the newly acquired relationship-building skills into daily life. After the counselor and the child agree that they have successfully developed a

relationship, attachment, or bond, the child will be encouraged to attempt to build a relationship with a member of the team. Because there is a great deal of risk taking that is involved in building relationships the team is a safe atmosphere in which to work on the skills. The parents become a part of this attachment building any time the child desires, however it must be the child's decision if the attachment is to be successful. Often the child is fighting many negative feelings toward the parents for causing the early attachment breaks and that child finds it is difficult to attach to them until these feelings have been resolved. Personal counseling is one way of resolving those feelings and it should be a continuous part of this treatment.

This proposed model is a baseline from where one can investigate the possibility of a child having an attachment disorder. As in any professional field, the use of personal techniques, talents and resourcefulness will add to the success of the investigation as well as to the impending treatment.

Implications for Counselors

Throughout the proposed model, the counselor must be a wealth of information and knowledge for everyone involved with the child. This requires research into the disorder which, hopefully, will result in understanding and empathetic acceptance of the child and the disorder.

The judgments which must be made will require self confidence and fortitude on the part of the counselor. Making judgments about another individual's life, especially a child's life, should be made only after careful, cautious thought and a great deal of questioning and consultation.

The greatest challenge in this model for the counselor is building a relationship with the child. Trained counselors should be able to provide soothing security and safety while serving as a base from which the child can explore the world. Similarly, these are the conditions under which the infant develops a secure attachment to his primary caregiver (Pistole, 1989). So in essence the counselor may be perceived as an attachment figure which would allow her access to the emotional and cognitive components of the child. Access to this part of the child's being is an imperative step in building a relationship.

The task of the counselor in this proposed model is two-fold. First, the counselor must orchestrate the model by taking charge and making sure that everyone knows their specific part of the process, and second, the counselor must

accept the role as personal counselor to the child. The author believes that counselors who are well trained and possess genuine caring instincts can be successful in helping a child who has an attachment disorder.

Implications for Teachers

Working with the unbonded child in the classroom can be very difficult. These children who can act out at a moment's notice, can also be defiant and belligerent, or do absolutely nothing, just take up space. A well known educator, Jim Fay (personal communication, Feburary 26, 1991) believes the classroom teacher, who feels the pressure to adequately educate the other children in the classroom and who has a problem type child can become very miserable and eventually this will affect teaching abilities.

The following are guidelines to assist the teacher when working with the unbonded child in the classroom. Many of these guidelines exemplify good teaching skills which will benefit the entire class. If the teacher can be understanding about the child's problem without being over sympathetic or intimidated by the child, handling her class will become much easier, even with the unbonded child. The teacher may possibly even feel rewarded that she can contribute to the child's mental well-being. The goal in dealing with unbonded children in the classroom is for the child to maintain acceptable behavior and the teacher to

maintain consistent discipline and consequences.

Fay and Cline (1986) provide the following guidelines for working with the unbonded child in the classroom:

1. Recognize that the teacher does not, and cannot do **therapy** for this student in the school setting.

2. The teacher should not sacrifice the other students by taking more than **fair share** time with this student.

3. The teacher's time and energy is better spent acting as an advocate for the student receiving the proper therapy.

4. Keep a tight reign. Never let him/her out of the consequence he/she creates. (If you do... then this will happen. And, be sure that he/she cannot avoid the consequences).

5. Set up a systematic suspension contract.

6. Sidestep power struggles by using Negative Assertion. (That's probably true, and this is what's going to happen.)

7. Replace unenforceable statements with enforceable statements. (Feel free to join the group as soon as you are willing to .....)

8. The well-being of the class takes priority over the well-being of this student. (All decisions are made based upon what is good for the class and school as opposed to what is good for this student).

9. Employ the **Sixty Second Scolding**.

10. The first nine guidelines should not be used as a way of avoiding teacher responsibilities to work effectively with children who are not diagnosed as having bonding or attachment problems.

The Survey

An informal survey was conducted at the beginning of this project to gain insight into what counselors in Wyoming knew about attachment disorders and what may be going on in addressing the problem in Wyoming public schools. It was found that 17 out of 26 respondents had **some** knowledge about attachment disorders, however 13 respondents cited lack of thourough knowledge as the biggest reason for not dealing with attachment disorders in their schools. Six respondents believed it was not the job of the school to deal with attachment disorders while just 2 respondents believed budget constraints were the biggest difficulty.

The overwhelming recommendation, with 18 respondents, was for staff education, inservice programs, workshops and education for the parents. Only 3 respondents felt that the school district was doing an adequate job of addressing attachment disorders. There were 5 respondents who believed that children with attachment disorders should be sent away to treatment centers regardless of the severity of the disorder.

These results indicate that there is knowledge about attachment disorders however, the level of knowledge is unknown. One could assume by the number of responses about the lack of knowledge, that the level of knowledge is not what most counselors would like it to be. Also, the recommendations point to the desire for more education about

the disorder for both school personnel and parents. The overall responses indicate that there is a need for education regarding attachment disorders so that attachment disorders can be addressed successfully within the public schools. The desire to help these children is evident by the desire to find out about the disorder. There seems to be a social conscience within the survey responses which is reassuring that many of the school districts care about their clientele as individuals who must become productive members of society.

CHAPTER 6

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

Attachment is the primary emotional connection that exists between human beings. It provides the structure upon which relationships are built. Development of this close, trusting, intrapersonal relationship will provide children with an internal core of trust and security. If children do not develop this internal core they will endure difficulties in many other aspects of his life.

The purpose of this paper has been to explore the literature in order to discover if the school setting can be an appropriate treatment option for children with mild attachment disorders. And if the school setting is appropriate, how the counselor can implement this treatment option?

The introduction discussed societal changes and how they may affect the future of children. With the family unit diversifying and in many cases, breaking up, children are becoming the casualties.

Chapter 2 explored the history of attachment citing several studies that depicted attachment as a real entity.

Both Bowlby and Ainsworth were instrumental in developing the field of attachment into a legitimate discipline of its own.

In Chapter 3 the theory of attachment was linked with Freud's (1938) work in psychoanalysis, Piaget's (1951) work in developmental psychology, and Lorenz's (1981) work of imprinting goslings. Each of these concepts are in evidence throughout the theory. Sroufe and Waters (1977) introduced 'felt security' and Schaffer and Emerson (1964) explained their thoughts of 'proximity-seeking behaviors'.

For a differing point of view the author cited Kagan, who believes that too much attention is being paid to early experiences and rejects the idea that parenting has significant impact on what the children can will become. He also believes that there is not enough empirical evidence to give attachment credibility as a theory.

Chapter 3 also addressed the emotionally charged day care issue. Studies on both sides of the controversy indicate that there is empirical evidence to support both sides. There was, however, an agreement that day care is here to stay and efforts must be extended to improve it.

The symptoms of attachment disorders were examined through the use of Table 1. The table presented the symptom, the observable manifestation of the symptom, the reason behind the behavior and a true example of the symptomatic behavior.

The Attachment Model was defined and illustrated in Chapter 4. The basic elements of this model are trust of caregiving, trust of control and trust of self. Attachment cycle disrupters such as; prebirth and birth factors, learning disabilities, physical handicaps, parenting factors, trauma, foster care and adoption were analyzed.

The author chose a continuum model (Figure 1) in which to demonstrate treatment options ranging in severity from personal counseling to psychiatric hospitalization and incarceration.

Chapter 5 posed the research question, 'can the school setting become an appropriate treatment option for children with mild attachment disorders? A model was proposed by the author which is to be a baseline structure for school counselors to use along with their own personal knowledge and techniques, in identifying and dealing with mildly attachment disordered children. Implications for the counselor included orchestrating the model and developing an attachment with the child. Implications for the teacher were in the form of 'guidelines for working with the unbonded child in the classroom'. Consistency in procedures and discipline were the main features of the guidelines.

A survey of a number of Wyoming school counselors indicated that knowledge about the disorder was very much needed in the schools.

Attachment, as viewed through the literature, is an

extensive, exciting, and fast growing concern which seems to have an impact on many aspects of an individual's life. More children are experiencing attachment difficulties now then ever before in history and something must be done to halt this increase or these untrusting, rage-filled children will become the majority instead of the minority.

Conclusions

As a result of a comprehensive study of the literature, this author is convinced that indeed the school can and should become a treatment option for the child who has a mild attachment disorder. Considering the fact that schools have a moral obligation to society, to exert every effort possible to help produce capable, intelligent mentally healthy individuals, this disorder should not be overlooked. It is also concluded that attachment disorders can be a precursor to many other disorders and maladaptive, inappropriate behaviors. If the inner core that was to be developed very early in life, for a number of reasons was not developed, the child will become an empty shell where there is no discrimination between right and wrong behavior. The child also will not develop cause and effect thinking and will soon become a child without a conscience.

Recommendations

There is no one answer that can possibly solve all the problems associated with attachment disorders, however if a concerted effort is initiated by parents and teachers society could witness significant changes in their troubled children. The efforts must not be just 'knee-jerk' reactions that are short-lived they must be well thought out plans that have structure and are on-going and far-reaching.

The key to any efforts directed at this problem is knowledge about the disorder. Curriculums and training programs on how to deal with this disorder and how to prevent this disorder must be implemented. Professionals and lay people both need to be recipients of this information, as education is the strongest weapon available with which to combat attachment disorders.

Research must also be encouraged in order to better understand attachments and to develop theories and models that professionals can utilize in their treatment of attachment disorders.

One of the most severe attachment cycle disrupters is the lack of parenting skills. Since the art of parenting is not inborn it must be learned at some point in an individual's life. In the past, parenting was learned from observing parents modeling good parenting skills and from interacting with siblings, grandparents and others in the extended family. Several members of the extended family

were usually within close proximity, geographically, which made interactions and observations very feasible. However, in today's world the extended family is often very far away and the immediate family is separated by divorce or other traumas in life. As a result, children are not learning how to become good parents. Another recommendation is to educate future parents by setting up programs in elementary schools which will teach students how to care for a child by using good and effective parenting skills. These student/parents would interact with infants and preschoolers under the supervision of teachers and parent helpers. This type of training could be extended to the secondary level also.

There are three recommendations that can be made concerning the day care issue. First, the government should enact a national leave policy to insure that parents have enough time to establish a bond with their child along with competent parenting patterns. Second, on-sight child care programs, at places of employment, should be encouraged with possible incentives for the employers. On-sight programs can actually save money through increased productivity and high employee morale. The third recommendation is for users of day care services to examine and scrutinize those services and demand changes where necessary to insure the best of care for their child.

Both foster care services and adoption services need to

reevaluate their programs with the goal of creating a more stable environment for the child by instituting more timely placements and fewer placements per child. Also, the child's records should be open to the foster and adoptive parents so they will have vital information concerning the child and his difficulties before they decide to accept the challenges of an attachment disordered child.

The last recommendation is for anyone who is involved or may become involved with a child who has an attachment disorder. Make every effort to meet the needs of the child, be it developing a relationship with him or getting him into an out patient program or recommending residential treatment. Children are the most important national resource and each one is deserving of the best care possible.

Final Remarks

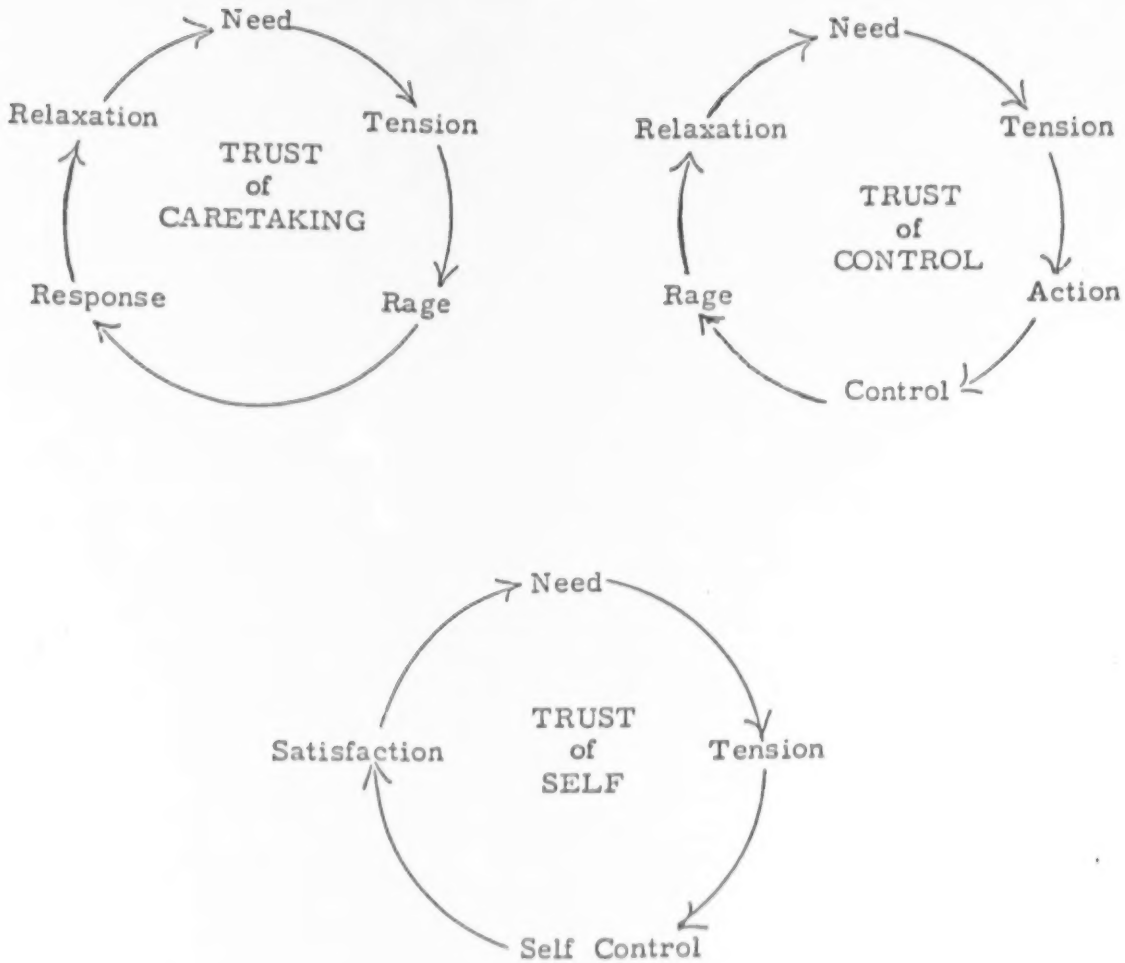
Creed and Masser expressed it best when they wrote the song "The Greatest Love of All" which states

I believe that children are
our future
Teach them well and let
them lead the way
Show them all the beauty
they posses inside
Give them a sense of
pride,
To make it easier
Let the children's laughter
Remind us how we used to be

"The Greatest Love of All"
Sung by Whitney Huston
Writers: Linda Creed & Michael Masser
@Golden Torch Music Company
(ASCAP) BMI

APPENDIX

The Attachment Model



Curtis, R. (1985). Attachment Model. Unpublished manuscript.

SELECTED REFERENCES

Ainsworth, M. S. (1967). Infancy in Uganda. Baltimore: The Johns Hopkins Press.

Ainsworth, M. D. S. (1973). The development of infant-mother attachment. In B. M. Caldwell & H. N. Ricciuti (Eds). Child Development and Social Policy. Chicago: University of Chicago Press.

Ainsworth, M. S., Blehar, M. C., Waters, E., & Wall, S. (1978). Patterns of attachment. Hillsdale: Lawrence Erlbaum Associates.

Allison, J. (1984). The who cares young people. Journal of Child Care, 2, 59-66.

Belsky, J. (1986). Infant day care: a cause for concern? zero to three. Washington D.C. Bulletin of the National Center for Clinical Infant Programs, 6, (5).

Belsky, J., & Rovine, M. J. (1988). Non-maternal care in the first year of life and the security of infant-parent attachment. Child Development, 59, 157-167.

Blatz, W. E. (1966). Human security; some reflections. Toronto: University of Toronto Press.

Blum, M. (1983). The day-care dilemma. Lexington: Lexington Books.

Bowlby, J. (1951). Maternal care and mental health. World Health Organization Monograph Series, (2).

Bowlby, J. (1962). Separation Anxiety: A critical review of the literature. New York: Child Welfare League of America.

Bowlby, J. (1969). Attachment and loss, volume 1, attachment. New York: Basic Books.

Bowlby, J. (1973). Attachment and loss, volume 2, separation, anxiety, and anger. New York: Basic Books.

Bowlby, J. (1982). Attachment and loss, volume 1, attachment (2nd ed.). New York: Basic Books

Bowlby, J. (1988). A secure base, parent-child attachment and healthy human development. New York: Basic Books.

Bretherton, I., & Waters, E. (1985). Growing points of attachment theory and research. Monographs of the Society for Research and Child Development, 50,(1-2, Serial No. 209).

Cline, F. W. (1979). Understanding and treating the severly disturbed child. Evergreen, Co.: Evergreen Consultants in Human Behavior.

Cline, F. W., & Fay, Jim. (1986). Guidelines for working with the unbonded child in the classroom. (Cline-Fay Institute Inc., Evergreen, Colorado).

Cornelius, S., & Denny, N. (1975). Dependency in day care and home care children. Developmental Psychology, 11, 575-582.

Curtis, R. (1985). Attachment Model. Unpublished manuscript.

Curtis, R. (Speaker). (1988). The nurturing classroom. [Cassette Recording]. Laramie, Wy.: Albany County School District Number 1.

Fagan, C.H. R. N. (1966). The effects of maternal attendance during hospitalization on the post-hospital behavior of young children: A comparative study. Philadelphia: F. A. Davis.

Fahlberg, V. (Ed.). (1990). Residential treatment, a tapestry of many therapies. Indianapolis: Perspective Press.

Fraiberg, S. (1977). Every child's birthright. New York: Basic Books.

Fraiberg, S. (1982). The adolescent mother and her infant. Adolescent Psychiatry, 10, 7-23.

Freud, A., & Burlingham, D. (1944). Infants without families. New York: International University Press.

Freud, S. (1938). Basic writings of Sigmund Freud. New York: The Modern Library.

Gosling, R. (Ed.). (1973). Support, innovation and autonomy. Tavistock Clinic Golden Jubilee Papers. London: Tavistock Publications.

Harlow, B. (1989, March). We're afraid of our son. Ladies Home Journal, pp. 18-27.

Harlow, H. F. (1971). Learning to love. San Francisco: Albion Publishing.

Hollingsworth, S. (1988, August). The uncertain fate of Wednesday's child. D Magazine, pp. 45-48.

Horejsi, C. R. (1979). Foster family care. Springfield: Charles C. Thomas.

Horejsi, C., & Gallacher, K. (1977). Guidelines for screening foster haoms for developmentally disabled children. Missoula, Montana: University of Montana. (Mimeo).

Jarboe, J. (1988, August). Full of woe. Texas Monthly, pp. 87-91.

Kagan, J. (1987). Unstable ideas. Cambridge: Harvard University Press.

Kagan, J., Kearsley, R. B., & Zalozo, P. R. (1978). Infancy, its place in human development. Cambridge: Harvard University Press.

Karen, R. (1990, February). Becoming attached. The Atlantic Monthly, pp. 35-70.

Lamb, M. (1982). Parent-infant interaction, attachment, and socioemotional development in infancy. In R. Ende & R. Harmon (Eds.). The development of attachment and affiliative systems. New York: Plenum Press.

Lamb, M., Thompson, R. A., Gardner, W., & Charnov, E. L. (1985). Infant-mother attachment: the orgins and developmental significance of individual differences in strange situation behavior. New Jersey: Lawrence Erlbaum Associates.

Lorenz, K. (1981). The foundations of ethology. New York: Springer.

Magid, K. (1989). Incapable of love. [Cassette Recording]. Lakewood, Co.: K.M. Productions.

Magid, K., & McKelvey, C. (1987). High risk children without a conscience. Toronto: Bantam Books.

Marvin, R. S. (1975). An ethological-cognitive model for attenuation of mother-child attachment behavior. In T. M. Alloway, L. Krames, & P. Pliner (Eds.), Advances in the study of communication and effect. New York: Plenum Press.

Maynard, F. (1985). The child care crisis. Onterio: Penguin Books.

McCarthy, D., Lindsay, M., & Morris, I. (1962). Children in hospital with mothers. Lancet, (i), 603-8.

McCartney, K., & Galanopoulos, A. (1988). Child care and attachment:a new frontier the second time around. American Journal of Orthopsychiatry, 58, 16-23.

McCord, W. M. (1982). The psychopath and milieu therapy. New York: Academic Press.

Meyerhoff, M. K. (1984, January). In response [Letter to the editor]. Young Children, p. 2.

Micic, Z. (1962). Psychological stress in children in the hospital. International Nursing Review, 9 (6), 23-31.

Piaget, J. (1951). The childs perception of the world. New York: Humanities Press.

Pistole, M. C. (1989). Attachment: implications for counselors. Journal of Counseling and Development, 68, 190-193.

Portnoy, F., & Simmons, C. (1978). Day care and attachment. Child Development, 49, 239-242.

Rayfield, S. (1990, August 19). Giving from the heart. Main and New Hampshire Sun-Journal, 7-14.

Reid, W. H. (Ed.). (1981). The treatment of antisocial syndromes. New York: Van Nostrand Reinhold Company.

Reid, W. H. (1985). The antisocial personality: a review. Hospital and Community Psychiatry, 36, (8), 831-837.

Sachs, A. (1990, June 4). When the lullaby ends. Time, p. 82.

Salter, M. D. (1939). The concept of security for a basis of the evaluation of adjustment. Unpublished doctoral dissertation, University of Toronto, Toronto.

Schaffer, H. R., & Callender, W. (1959). Psychological effects of hospitalization in infancy. Pediatrics, 24, 528-539.

Schaffer, H. R., & Emerson, P. E. (1964). The development of social attachments in infancy. Monographs of the Society for Research in Child Development, 29(3, Serial No. 94).

Shroeder, P. (1987). Foreward. In K. Magid & C. McKelvey, High risk children without a conseience, (p. 14). New York: Bantam Books.

Schwartz, P. (1983). Length of day care attendance and attachment behavior in eighteen mont old infants. Child Development, 54, 1073-1078.

Spitz, R. (1965). The first year of life, a psychoanalytic study of normal and deviant development of object relations. New York: International Universities Press.

Sroufe, L. A., & Waters, E. (1977). Attachment as an organizational construct. Child Development, 48, 1184-1199.

Staff, (Ed.). (1988). Attachments. (Available from [Attachment Center at Evergreen, PO Box 2764, Evergreen, Co.]).

Staff, (Ed.). (1989). Attachments. (Available from [Attachment Center at Evergreen, PO Box 2764, Evergreen, Co.]).

Staff, (Ed.). (1990). Attachments. (Available from [Attachment Center at Evergreen, PO Box 2764, Evergreen, Co.]).

Trenberth, G. (Ed.). (1988). Family Ties. (Available from [ADPN, PO Box 12127, Boulder, Co.]).

Trenberth, G. (Ed.). (1989). Family Ties. Available from [ADPN, PO Box 12127, Boulder, Co.]).

Trenberth, G. (Ed.). (1990). Family Ties. Available from [ADPN, PO Box 12127, Boulder, Co.]).

Valente, W. D. (1980). Law in the schools. Columbus: Charles E. Merrill Publishing.

Welch, M. G. (1987). Toward prevention of developmental disorders. Pennsylvania Medicine, 90, 47-52.

White, B. L. (1985, October). Should you stay home with your baby? American Baby, pp. 27-30.

Winnicott, D. W. (1987). Babies and their mothers. Reading: Addison-Wesley.

Yarrow, L. J., & Goodwin, M. S. (1973). The immediate impact of separation: Reactions of infants to a change in mother figures. The Competent Infant. New York: Basic Books.

Zigler, E. F., & Gordon, E. W. (1982). Day care: scientific and social policy issues. Boston: Auburn House.

CONTRIBUTORS

Individuals

Chapman, David
Case Manager, Albany County Schools, Laramie, Wyoming

Cline, Foster MD
Evergreen Consultants in Human Behavior
Cline-Fay Institute, Evergreen and Golden, Colorado

Curtis, Ray MSW
Social Services Director, Forest Heights Lodge
Evergreen, Colorado

Fay, Jim
Educational Consultant, Cline-Fay Institute
Golden, Colorado

Lynch, Jeanette MSW
Southeast Mental Health Center, Cheyenne, Wyoming

McKelvey, Carole
Rocky Mountain Women's Institute, Denver, Colorado

Meyers, Marty MD
Psychological Associates, Ft. Collins, Colorado

Institutions

Cline-Fay Institute
Educational and Psychiatric Consultants
Golden, Colorado

Evergreen Consultants in Human Behavior
Treatment, Diagnostic, Educational and Training Services
Evergreen, Colorado

Forest Heights Lodge
Residential Treatment Center
Evergreen, Colorado

The Attachment Center at Evergreen
Theraputic Foster Homes Treatment
Evergreen, Colorado

Associations

Attachment Disorder Parents Network (ADPN)
Boulder, Colorado

Attach
Association for Treatment and Training in the Attachment of Children
Dallas, Texas

Foster parents Support Network
British Columbia, Canada

Auxillary Contributor

"The Greatest Love of All"
Sung by Whitney Huston
Writers: Linda Creed & Michael Masser
@Golden Torch Music Company
(ASCAP) BMI